North East **LHIN**

Integrated Health Service Plan (IHSP)

North East **LHIN**
RLISS du Nord-Est

November 30, 2009

To: Residents of North East Ontario
Ontario Minister of Health and Long-Term Care
North East Health Service Providers and Partners in Health

The North East Local Health Integration Network (NE LHIN) is pleased to release its second Integrated Health Services Plan (IHSP) that outlines nine strategic priorities for the period 2010/11 to 2012/13 for the region.

This is ***our*** plan for the health system (i.e. it belongs to individuals, communities, health service providers, health partners, the LHIN and the Ministry of Health and Long-Term Care). Changing a complex system such as health care cannot be done single-handedly – it is a collective endeavour.

Behind every health statistic is a person. Some of the region's indicators are good – others not. There are major issues and inequities within the North East that we are compelled to address – they cannot be ignored or hidden behind a statistic. For example: the living conditions and health of the people on the James and Hudson Bay Coasts; access to services for Francophone residents in their own language; seniors living in long-term care homes or waiting in hospitals (i.e. as alternate level of care) who would be better served in other settings such as supportive housing; wait times for life changing procedures; and access to basic primary care for every person in the region.

Through this IHSP, it is the LHIN's hope and expectation that together we will make a difference.

On behalf of the NE LHIN Board of Directors and Staff,

Peter Vaudry
Interim Board Chair
Officer

Terry Tilleczek
Interim Chief Executive

Ontario

TABLE OF CONTENTS

SECTION 1: INTRODUCTION 2

SECTION 2: SUMMARY OF THE PROVINCIAL STRATEGIC PLAN AND ALIGNMENT OF IHSP 3

SECTION 3: THE NORTH EAST LHIN'S VISION FOR THE HEALTH CARE SYSTEM 5

SECTION 4: OVERVIEW OF THE NORTH EAST HEALTH CARE 6

SECTION 5: FRAMEWORK FOR PLANNING 9

SECTION 6: PRIORITIES AND STRATEGIC DIRECTIONS FOR THE NORTH EAST HEALTH SYSTEM 12

- Aboriginal / First Nations / Métis Health Services 12
- Addiction and Mental Health Services 14
- Aging at Home 15
- Alternate Level of Care (ALC) Strategies and Solutions 17
- Diabetes Care 19
- Emergency Department Wait Times 20
- French Language Health Services - An Integrated Approach 21
- Health Human Resources 22
- Optimize Surgical Services 23

SECTION 7: RATIONALE FOR THE STRATEGIC DIRECTIONS 24

SECTION 8: HOW SUCCESS WILL BE DEMONST RATED AND MEASURED 26

North East Local Health Integration Network
555 Oak Street East, 3rd Floor
North Bay, ON P1B 8E3
Phone: 705-840-2872 or 1-866-906-5446
Email: northeast@lhins.on.ca
Website: www.nelhin.on.ca

SECTION 1: INTRODUCTION

Health care is both a people issue and a community issue.

This Integrated Health Service Plan (IHSP) 2010-2013 reflects the collective thoughts and expectations of consumers, patients, families, health service providers, executives and health service organization boards of directors from across North East Ontario. Many of the engagement sessions held through our ***Engage 2009*** activities also reflected the cultural diversity of our region and included discussions with Francophone, Aboriginal, First Nation and Métis people.

The North East Local Health Integration Network (NE LHIN) has, and will continue to, actively listen to the people we serve. We will continue to challenge the way health care is delivered in North East Ontario so that the NE LHIN vision of ***'health and wellness for all'*** becomes a reality.

The following NE LHIN priorities have been identified for the next three years:

- **Aboriginal / First Nations / Métis Health Services**
- **Addiction and Mental Health Services**
- **Aging at Home**
- **Alternate Level of Care Strategies and Solutions**
- **Diabetes Care**
- **Emergency Department Wait Times**
- **French Language Health Services – An Integrated Approach**
- **Health Human Resources**
- **Optimize Surgical Services.**

The IHSP priorities above are not independent; they interconnect with one another and together they will help to ensure the long-term sustainability of our health care system while allowing individuals greater access to quality care in North East Ontario. The implementation of these priorities will be approached through innovations in information/communications technology and electronic processes.

It is evident that one of the overarching directions of the NE LHIN is not noted in this list of nine priorities - ***integration***. Rather, integration is an ***approach*** that will be included in all of our collective work. It is a ***shared*** responsibility. The only way the NE LHIN region can witness improved coordination within the local health care system is through greater collaboration among all partners. Our commitment to community engagement and the development of partnerships will continue as we together act on the priorities within our IHSP.

SECTION 2: SUMMARY OF THE PROVINCIAL STRATEGIC PLAN AND ALIGNMENT OF IHSP

As partners in planning for the necessary improvements to health care in Ontario, both LHINs and the Ministry of Health and Long-Term Care (MOHLTC) play important roles. The MOHLTC sets and shares its strategic vision and priorities. Within their IHSPs, the LHINs align with the Ministry's strategic directions, while at the same time setting additional priorities that make sense at the local level.

The MOHLTC is currently developing a 10-year strategic plan for Ontario's health system. Like other LHINs, the NE LHIN's IHSP supports the Ministry's planned priorities to promote equitable access to health and health care for all Ontarians, and improve access to care in three areas:

1. Reducing wait times in emergency departments
2. Reducing the time patients spend in alternate level of care beds in hospitals
3. Supporting the roll-out of Ontario's Diabetes Strategy.

The Ministry has also identified mental health and addictions, and eHealth as key focus areas, both of which we currently support through our strategic priorities and activities.

Reducing Emergency Department Wait Times

Ontarians are entitled to safe, reliable, appropriate and high quality care when they visit an emergency department. Timely access to care can significantly improve a patient's experience, which is why reducing emergency department wait times is one of the Ontario Government's top health care priorities.

Experience tells us that a backlog in one area of the health system can result in delays in many other areas. To achieve shorter emergency department wait times, LHINs need to improve the efficiency of care delivery across the entire health system. We also know that patients with non-urgent or less urgent needs account for about half of all emergency department visits, so we need to look at ways to build care capacity within the community so people can access appropriate care outside emergency departments.

Under the Ministry's direction, LHINs are working to meet provincial targets and publicly report emergency department wait times.

Reducing Time in Alternate Level of Care (ALC) Beds

When patients complete the acute care phase of their treatment in hospital, they often remain in acute care beds while they wait to be discharged or transferred. They need an "alternate level of care" – but none is available.

Close to 19% of patients currently in Ontario hospital beds are waiting for an alternate level of care opening, such as a long-term care or rehabilitation care bed. This often leads to longer wait times in the emergency department as patients wait in that department to be admitted to the hospital.

The LHINs are working with the Ontario government on a variety of initiatives that will help patients get the care they need – whether that's in a hospital, long-term care home, rehabilitation care facility, in the community or at home.

Supporting Ontario's Diabetes Strategy

Ontario's Diabetes Strategy will help tackle a growing – and expensive – health care challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population). This number has increased by 69% over the last 10 years, and is projected to reach 1.2 million by 2010. Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion each year.

The provincial Diabetes Strategy will improve access to prevention programs and team-based care. The Strategy includes an online diabetes registry which is an electronic information, diagnostic, and educational tool that will enable health care providers to monitor patients living with diabetes. The registry will include best practice guidelines, alerting clinicians of the need for recurring diagnostic tests, and will give patients access to information and educational tools to help them better manage their diabetes.

The LHINs are committed to improving access to diabetes care by supporting the roll-out of the provincial Diabetes Strategy.

Enhancing Mental Health and Addictions Services

At some time in their lives, about 20% of Ontarians – one in every five people – will experience a serious mental illness or harmful substance use, and 5% will have a serious problem with gambling. Between 15% and 21% of children and youth in Ontario have at least one mental health issue; and 10% to 25% of seniors experience mental health disorders. The cost of preventing and treating mental illnesses and addictions is only a fraction of what these illnesses cost society in lost productivity and other social costs. In fact, investing in actively supporting people to stay mentally healthy saves money. Every $1 spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.

The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. For the first time, the province's strategy looks beyond health to include mental health and addictions services funded by other provincial ministries.

The LHINs will implement the provincial mental health and addictions strategy, helping to create a system that provides everyone who needs care with equitable access to safe, respectful and effective services.

Building on an eHealth Framework

In March 2009 the Ontario government released a provincial eHealth Strategy which focuses on: diabetes management, medication management, and wait times. Through information and communication technology investments that support clinical collaboration and seamless service delivery such as the diabetes registry, Wait Times Information System and electronic health records, the Ministry aims to improve access to information and support the delivery of high quality health care for patients across the province.

Imagine: A Healthier Ontario

The Ontario Government's strategic directions helped to shape this Integrated Health Service Plan. By aligning local initiatives with provincial priorities, we can provide appropriate, coordinated, safe and efficient health services. We can also achieve our common goal of healthier people, healthier communities and a healthier system for all.

Find out more: visit the Ontario Ministry of Health and Long-Term Care website at www.health.gov.on.ca

SECTION 3: THE NORTH EAST LHIN'S VISION FOR THE HEALTH CARE SYSTEM

NE LHIN Vision

Health and Wellness for All ...
through an innovative, sustainable and accountable system.

The successful implementation of the NE LHIN vision relies on the shared responsibility to deliver quality health care programs and services across North East Ontario. An integrated, patient-focused health care system can only be realized when all health service providers and organizations work together with a common approach. The NE LHIN will continue to strengthen its partnerships to allow for a cohesive approach to *health and wellness for all*.

Values	Behaviours
Listen	Our intention: You will be heard.
Integrity	Responsible and accountable for living our values.
Proactive	Anticipate needs and opportunities – and act appropriately.
Equity	Opportunity for health and wellness for all.
Serve	Include NE Ontario geographic, cultural, demographic, and linguistic health & wellness needs in all activities.

NE LHIN Integration Strategy

A key component to help achieve the NE LHIN's vision is our ***Integration Strategy*** (September, 2008). This Strategy is built upon the need to appropriately plan and make the necessary system and service level changes that:

- Enhance access to, and quality of, health services
- Improve individual and population health outcomes
- Improve the overall patient experience within the health system by reducing fragmentation and duplication
- Realize greater efficiencies through the most effective use of available resources.

The NE LHIN supports integration initiatives that demonstrate action, priority setting and coordinated health service planning.

While a number of integration priorities will continue to be led by the NE LHIN (e.g. wait times), other priorities will benefit from a community and planning area approach to achieve seamless and patient-focused health services that are planned and supported by partnerships.

The overarching goal of the NE LHIN Integration Strategy is to achieve the following outcomes at each of the community, planning area and regional levels: unity of governance, planning, action and evaluation leading to enhanced service delivery and sustainability.

In the context of our ***Integration Strategy*** and as noted in the ***Towards Unity for Health Framework*** (World Health Organization, 2000, p. 29), 'unity' represents the degree by which different partners or stakeholders share a commitment to meeting people's health needs through a system organized around the values of quality, equity, relevance and cost-effectiveness. Attention is focused on integration of the whole range of individual - and population-based health activities with the assumption that integration will initiate a cascade effect and lead to a holistic approach in the health care system at large.

The NE LHIN recognizes that opportunities, priorities, readiness and completed integration-related planning work vary by community, planning area and within the region. It is the responsibility of health service providers and partners at the various levels to identify the path to achieve the necessary outcomes.

Integration is not a project which stands alone – it is an approach that must be embedded in all NE LHIN and health service provider work.

SECTION 4: OVERVIEW OF THE NORTH EAST HEALTH CARE SYSTEM

This section summarizes key socio-economic and health status information about the citizens of North East Ontario.

Population Profile

The NE LHIN represents over 40% of the province's land area and 4.5% of the population. Since the 2001 Census, population growth in the NE LHIN region has been less than 1%, in comparison to the provincial growth rate of nearly 8%.

Planning Area	Total Population	% of NE LHIN
Algoma	117,461	21.3%
Cochrane	78,692	14.3%
James and Hudson Bay Coasts*	4,258	0.8%
Manitoulin-Sudbury	192,392	34.9%
Nipissing	84,688	15.4%
Parry Sound	40,918	7.4%
Timiskaming	33,283	6.0%
North East LHIN	**551,691**	**100.0%**

Statistics Canada Census, 2006. The total does not add up to 100% due to the effects of rounding.
**This is an under-count by at least 50% due to varying levels of participation in the Census by First Nations communities.*

Overall, compared to the province (based on 2006 census), the North East has a higher:

- Proportion of the population with Aboriginal identity (10% vs. 2%). Note – this is an under-count for the North East
- Proportion of Francophones (24% vs. 4%)
- Proportion of population living in rural areas (30% vs. 15%)
- Proportion of people over the age of 65 (17% vs. 14%)
- Unemployment rate for ages 15+ (8% vs. 6%)
- Proportion of the population age 25 and over who do not have a high school (or equivalent) certificate (26% vs. 19%).

Health Behaviours and Health Status

Compared to the province (based on the Canadian Community Health Survey 4.1, 2007, for individuals 12 years and over), the North East has a higher:

- Percentage of current smokers (27% vs. 21%)
- Percentage of adults who are current drinkers reporting heavy drinking (27% vs. 21%)
- Percentage of adults (age 18+) who are obese (22% vs. 16%)
- Prevalence of high blood pressure (21% vs. 16%).

The North East is also associated with a lower:

- Proportion of the population who report having contacted a medical doctor in the past 12 months (76% vs. 81%)
- Proportion of the population rating their health as very good or excellent (55% vs. 60%)
- Proportion of population reporting no exposure to second hand smoke at home (68% to 73%). This is an improved rate in the North East from 56% in 2003.

North East LHIN citizens are doing as well as or better than Ontarians overall in the following areas:

- Moderately active or active level of physical activity (50% vs. 49%)
- Proportion of the population with a somewhat strong or very strong sense of belonging to the community (66% vs. 63%)

- Very good or excellent perceived mental health (71% vs. 73%).

The leading causes of death in 2004 for NE LHIN residents, as well as all Ontarians, were circulatory system diseases (such as heart disease and strokes) and neoplasms (cancer). Age-standardized mortality rates for these diseases, as well as respiratory system diseases, external causes of death such as injuries and poisonings, digestive system diseases, and endocrine, nutritional and metabolic system diseases (which include diabetes) are significantly higher in the North East compared to provincial rates. The life expectancy for males and females in North East Ontario is lower in comparison to the province as a whole.

The top two leading causes of hospitalization (with respect to volume) are circulatory system diseases and digestive system diseases. The rate of hospitalization due to injuries in 2006 was significantly higher for citizens of North East Ontario compared to the rest of the province (652 hospitalizations/100,000 people vs. 434 hospitalizations/100,000 people).

Access to Health Services

- Relative to the 2008/09 provincial targets:
  - Wait times in the North East are too long for joint replacements (i.e. hips and knees)
  - The proportion of days spent in the hospital after the acute phase of treatment is over (i.e. alternate level of care days) is high in relation to the total number of acute hospital days in the North East region.

- The North East region fares well in comparison to provincial wait time targets for:
  - Cancer surgery
  - Cardiac bypass procedures
  - Rate of emergency visits that could be managed elsewhere
  - Cataract surgery, diagnostic CT and MRI scans, and the hospitalization rates for ambulatory care sensitive conditions are improving in the North East
  - The readmission rate for acute myocardial infarction (heart attack) is close to the LHIN target of 6% but still above the provincial goal of 3.8%
  - The median wait time to long-term care home placement is currently above the NE LHIN's target for 2008/09 and well above the provincial target of 50 days
  - For the past year, the average length of stay in emergency departments in North East LHIN hospitals was slightly above 8 hours for complex conditions (both admitted and non-admitted cases) and slightly below 4 hours for minor or uncomplicated conditions (non-admitted cases only). These rates are at or below the current provincial times and targets.

Health Services in the North East LHIN

Number	Health Organizations and/or Programs
26	General Hospitals
1	Specialty Mental Health Facility
1	Regional Cancer Centre
1	Community Care Access Centre
76	Community Support Service Programs
41	Long-Term Care Homes
40	Community Mental Health Programs
10	Problem Gambling Programs
26	Substance Abuse Programs
5	Community Health Centres
1	Group Health Centre in Sault Ste. Marie

Additional population and health service provider information for the North East LHIN can be found at www.nelhin.on.ca.

SECTION 5: FRAMEWORK FOR PLANNING

Given the geographic size (400,000 square kilometres) and the diversity of North East Ontario (24% Francophone 10% Aboriginal / First Nation / Métis), seven planning and community engagement areas have been created within the region.

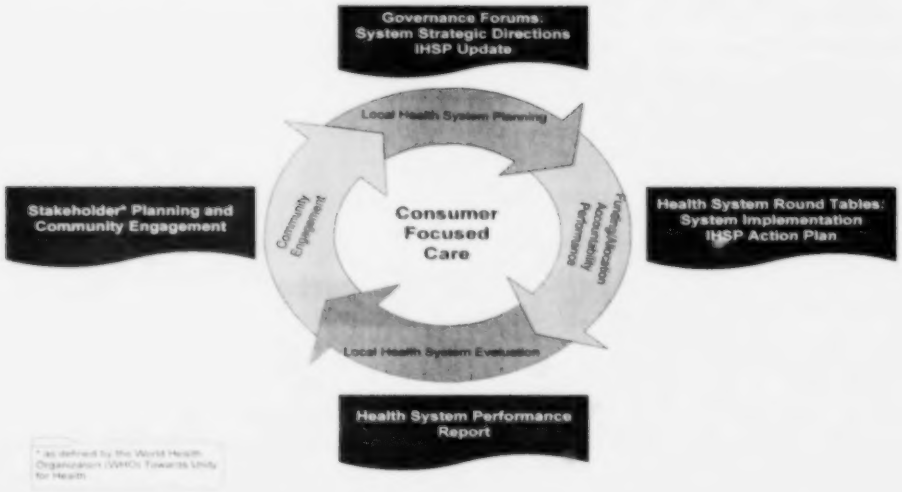
The development of these geographic areas is intended to enhance, not limit, planning and community engagement with the recognition that clients and service providers cross these boundaries.

The planning areas are:

- Algoma
- Cochrane
- James and Hudson Bay Coasts
- Manitoulin-Sudbury
- Nipissing
- Parry Sound
- Timiskaming.

NE LHIN Region

NE LHIN Planning and Engagement Cycle



LHINs are responsible for community-based planning, integration facilitation, local priority setting, system performance monitoring, and resource allocation. The NE LHIN has established a network of Health System Round Tables, committees (e.g. Health Professionals Advisory Committee, Local Aboriginal Health Committee, Interim French Language Service Planning Entity, eHealth Advisory Council, Health Human Resources), and project or task-specific groups as required to support our planning work.

Creating a Health Care System

Who are our partners and what are the various roles and responsibilities in ensuring that our health system is well designed and managed?

A starting point to answering this question is the province of Ontario and the Ministry of Health and Long-Term Care where legislative, policy and resource allocation decisions are made. Expectations for performance, system monitoring and provincial planning help to shape the considerations that guide local initiatives. These provincial priorities reflect feedback received from the 14 LHINs and the many communities that they serve.

In addition to having many common needs, each community is unique. Health care issues and initiatives must be tailored to fit and complement each local context. Input and feedback from all stakeholders is a crucial component to this customization. Health service consumers and their families know what is working well, where improvements can be made, and what services are missing. Local health service providers are a pivotal source for creative solutions to the challenges faced. Other community members, who are not currently consumers or providers, also offer insightful observations from a neutral perspective.

Our collective task is that of aligning the identified priorities and implementing the needed solutions. The primary responsibility of the NE LHIN is to facilitate the action needed to maintain a high quality health care system and to make the improvements necessary. The NE LHIN must ensure that actions are fair and equitable, and that relevant information and facts are taken into account.

SECTION 6: PRIORITIES AND STRATEGIC DIRECTIONS FOR THE NORTH EAST HEALTH SYSTEM

This section presents details on the priorities and the expected outcomes for the next three years.

The following nine priorities have been identified as those that are shared across the entire province (as discussed in Section 2) and those that reflect the unique needs of the NE LHIN. These priorities build upon the first IHSP and the discussions with communities that occurred through the ***Engage 2009*** process. They are:

- Aboriginal / First Nations / Métis Health Services
- Addiction and Mental Health Services
- Aging at Home
- Alternate Level of Care Strategies and Solutions
- Diabetes Care
- Emergency Department Wait Times
- French Language Health Services – An Integrated Approach
- Health Human Resources
- Optimize Surgical Services.

All of these areas are interconnected and interdependent. Within these priorities, we will seek to reinforce the need for prevention within our system wherever possible – keeping people healthy and able to access care when needed.

Information and communications technology (ICT) solutions are key enablers for each of our nine priorities and will be leveraged to support service integration and the delivery of quality care. As with most health care initiatives, ICT projects reap the greatest benefit when they:

- Enhance patient care services or access to services
- Are part of a broader regional strategic ICT plan
- Use a multi-agency or multi-sectoral partnership approach
- Have a sound business case
- Can be used as foundational elements in the creation of an electronic health record.

ABORIGINAL / FIRST NATIONS / MÉTIS HEALTH SERVICES

The NE LHIN has focused on building meaningful relationships with Aboriginal / First Nations / Métis communities within our region in an effort to improve the health status and services for this population that represents 10% (this is a conservative estimate) of the overall North East LHIN population. The main objective for the NE LHIN in relation to Aboriginal health services is to align with existing Aboriginal / First Nations / Métis regional, provincial and federal health planning, program and service delivery structures to improve health outcomes.

The NE LHIN respects Aboriginal / First Nations / Métis rights to determination in health and utilizes the Ontario Aboriginal Health Policy where applicable. This respect and understanding is also reflected in the NE LHIN Integration Strategy where Aboriginal / First Nations / Métis integration principles are identified. In all areas of operation, advice and guidance are sought from the Aboriginal health service providers funded by the NE LHIN.

It was clear through the IHSP engagement process that the needs of Aboriginal communities in the North East are significant in scope and magnitude. Yet there is also considerable use of mainstream services and programs. For these reasons, Aboriginal / First Nations / Métis health and health services is a priority on its own but must also be a component of, and measured against, all other IHSP priorities.

The NE LHIN's Local Aboriginal Health Committee (LAHC) was established to advise the NE LHIN of priorities within Aboriginal (First Nation, Métis, urban, rural) communities. This includes the identification of priority health care needs and opportunities for the integration and coordination of health care services. The LAHC also advises the NE LHIN where targeted engagements with specific Aboriginal populations are required, pertaining to the work of the NE LHIN and the needs of those populations.

Planning activities with Aboriginal / First Nations / Métis people include:

- Seniors' engagement activities to support the Aging at Home Strategy
- Meetings with First Nations' Health Directors, Aboriginal Health Access Centres, and the Ontario Federation of Indian Friendship Centres
- Aboriginal representation on each of the NE LHIN Planning Area Health System Round Tables
- Support for *Our Health Counts* project to include Aboriginal people in health records
- A literature review analyzing existing Aboriginal programs and population data sets
- An Aboriginal Health Summit to develop a formal Aboriginal health planning structure for the North East LHIN.

Expected Outcomes:

- Continue consultations and engagement with leaders, tribal councils, and health service providers
- Continue relationship building with provincial and federal health initiatives to maximize alignment of planning processes, programs and services
- Create a culturally appropriate evaluation framework for Aboriginal / First Nations / Métis health service development
- Produce and update a health provider profile and environmental scan relative to Aboriginal health needs
- Develop a North East Aboriginal / First Nations / Métis mental health and addictions strategy
- Improve access to integrated diabetes care through support of the current Diabetes Strategy
- Improve access to primary care for Aboriginal / First Nations / Métis people
- Increase access to culturally appropriate care and traditional healing services.

ADDICTION AND MENTAL HEALTH SERVICES

Studies indicate that approximately one in five Canadians is likely to experience a mental health and/or addiction problem at some point in his or her life; however, many of these problems are untreated. People seeking mental health or addiction services are often unable to access the help they need or choose not to access help because of the stigma associated with these conditions.

The existence of separate treatment programs for mental health and addiction, separate funding envelopes, and differing treatment approaches are all significant barriers to the effective support for persons with addiction and/or mental health problems (as many as 50% of people suffering from mental illness also face an addiction). An integrated addiction and mental health system in North East Ontario will help to address the needs of individuals and communities across the region. An integrated system also has the potential to create better links with other key areas such as housing, income, employment, and social supports that are all important components to providing a comprehensive approach to mental health and addiction treatment and support.

Potential Benefits of Addiction and Mental Health Program Integration
• **Improved access and awareness for health care consumers** through the development of a system that is easily understood.
• **Quality enhancement** resulting from shared staff and expertise.
• **Staff growth, development and education** with better employment, staff development and training opportunities.
• **Recruitment and retention of health professionals** using shared strategies.
• **Improved efficiencies and more resources for direct care** through program and administrative savings.

Expected Outcomes:

- Addiction and mental health integration will continue to be featured in ongoing community discussions. The NE LHIN will continue to provide leadership and will call for integration proposals for addiction and mental health programs. Support and funding to facilitate the integration process will be sought.
- Policy and legislative challenges to coordination, such as the removal of multiple reporting systems, will be examined.
- Ongoing opportunities to meet and network regionally to explore integration and exchange information will be pursued.
- An inventory of integration resources including best practice information and an information exchange will be created.
- The NE LHIN continues to plan for the delivery of Regional Mental Health and Addiction services through the Regional Advisory Panel (RAP) as well as district planning groups.
- Information technology and client assessment expertise to enhance treatment planning and outcome monitoring will continue to be explored with the implementation of the Ontario Common Assessment of Need solution in the North East.
- The NE LHIN will continue to consult with the MOHLTC on the development and implementation of the Ministry's 10-year addiction and mental health strategic plan.

AGING AT HOME

Based on the advice obtained through ***Engage 2009***, this priority has been positioned as a combination of the provincial Aging at Home Strategy with the broader need for services for seniors and others requiring assisted living supports. Ensuring that the right number of housing options and supports is available for seniors is a key focus for the NE LHIN in an attempt to alleviate alternate level of care (ALC) pressures and more appropriately care for our seniors.

The NE LHIN's *Aging at Home Directional Plan* and *Detailed Services Plan* have helped to determine the allocation of the three years of Aging at Home Strategy funding across the region (i.e. 2008/09 to 2010/11). The aim of this Strategy is to create a continuum of community-based services for seniors and their caregivers that will enable them to live independently and safely in their own homes for as long as possible.

The Aging at Home Strategy is targeted at:

- People aged 65 years and over (55 and over for the Aboriginal population)
- Individuals close to age 65 who are dealing with age-related health conditions and/or disabilities
- Family, friends and neighbours who care for seniors in the community.

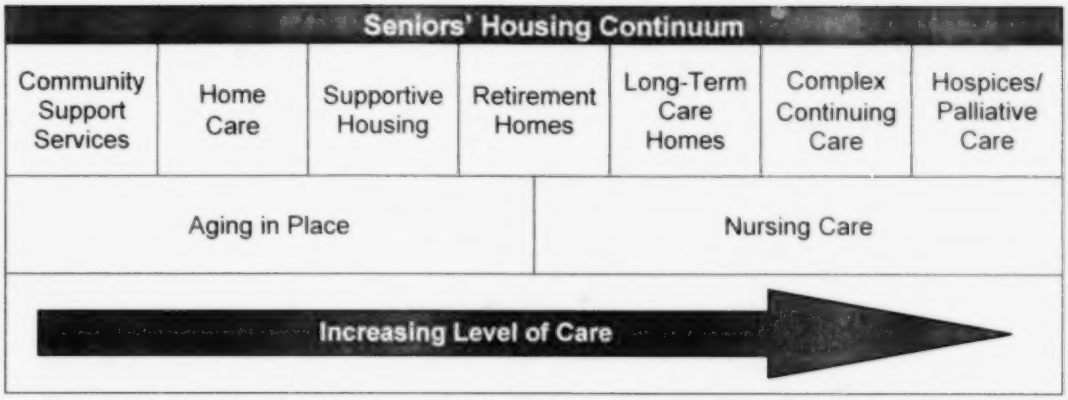
The NE LHIN is already in the process of identifying and implementing new and creative programs in the 2009/10 and 2010/11 budget years. The NE LHIN has used the following principles when implementing of the Aging at Home Strategy:

- **Senior centered** – services must respond to the needs of seniors
- **Community-based and integrated** – with the broader health care system
- **Equitable** – recognize demographic and geographic challenges
- **Cost-effective** – best care at optimal cost while recognizing the benefits of volunteerism and developing local community responses
- **Results-oriented** – results must be defined and measured
- **Local community oriented** – build on community capacity and be culturally sensitive.

Supportive housing / assisted living needs are closely linked to the ALC challenge, particularly for seniors. For this reason, the NE LHIN has completed a planning study that resulted in the report *Seniors' Residential/Housing Options – Capacity Assessment and Projections*, March 16, 2008 (www.nelhin.on.ca).

This report looks at the current and future needs of seniors for long-term care, retirement living, and supportive housing. It identifies the expected rapid rise in the senior population over the next 25 years and indicates that ongoing efforts are needed to increase the amount of housing options available for this growing population.

It is also important that the housing options available to seniors are affordable; with many seniors in the North East having limited personal financial resources.



Our housing study applied a '*balance of care*' analysis that illustrates how some of the future needs for long-term care could be reduced with the addition of supportive housing units. Between 32% and 69% of individuals waiting for a long-term care home could have their housing needs met through a supportive housing setting. High, medium and low diversion rates were developed to better outline this finding. The tables below present the number of beds or units that would be required in 2011 and 2031 based on the medium diversion scenario.

A comparison of current supply for 2011 demand estimates suggests an overall shortage of approximately 2,604 beds/units in the short-term. Of note is that if the supportive housing supply were dramatically increased there would be an excess of long-term care capacity both in the short- and long-term.

Housing Form	2008 Supply	2011 Demand Estimate (Medium Diversion Rate)	2011 Gap Estimate
Long-Term Care Beds	4,766	2,824	-1,942
Retirement Home Beds/Suites	1,896	2,150	254
Supportive Housing Units	533	4,782	4,249
Convalescent Care Beds	30	56	26
Residential Hospice Beds	20	37	17
Total	**7,245**	**9,849**	**2,604**

Housing Form	2008 Supply	2031 Demand Estimate (Medium Diversion Rate)	2031 Gap Estimate
Long-Term Care Beds	4,766	4,407	-359
Retirement Home Beds/Suites	1,896	3,575	1,679
Supportive Housing Units	533	7,514	6,981
Convalescent Care Beds	30	96	66
Residential Hospice Beds	20	62	42
Total	**7,245**	**15,654**	**8,409**

Expanding the supportive housing supply would provide a more appropriate living setting for a large number of seniors and enable needs to be met at a significantly lower cost compared to the expanding number of long-term care home beds.

Expected Outcomes:

In addition to focusing on the following outcomes, it will be important to ensure that the links to and coordination of services are improved, including:

- Increase in overall supply (quantity and range) and coordination of services available to seniors
- Relieve pressures on hospitals and long-term care homes by helping to find more appropriate placements for patients and avoiding crisis through proactive wellness approaches
- Improve access and reduce barriers to services for seniors
- Address gaps in services to support seniors at home
- Achieve clinical and operational excellence through evidence-based practice
- Improve safety for seniors
- Increase service efficiencies
- Establish a Seniors' Housing Coordinating Committee to identify the details and funding requirements to develop the appropriate level of program delivery in the region
- Advocate for increased capital funding and ongoing support service funding to enable the expansion of senior supportive housing
- Identify opportunities for more specialized long-term care homes to accommodate individuals with complex care needs
- Partner and promote senior housing initiatives in Aboriginal communities to enhance the provision of supports to Aboriginal seniors living in First Nations' communities
- Expand prevention programs in existing housing programs to reduce the incidence of hospitalization and movement to long-term care (e.g. falls' prevention).

ALTERNATE LEVEL OF CARE (ALC) STRATEGIES AND SOLUTIONS

Hospitals across Ontario continue to experience the pressures of ALC. The inappropriate use of acute care beds for ALC patients places great pressure on hospitals to deliver acute care services due to a significant reduction in patient flow within the health care system.

A transition period between acute care and the next level of care cannot, in some cases, be avoided. However, when patients are unable to move in a timely fashion to a more appropriate type of care, the consequences are felt throughout the entire health care system. Wait lists grow and emergency departments are unable to admit patients due to a lack of acute care beds.

Comparing LHIN regions, the percent of acute care beds occupied by ALC patients is highest in the North East. The current ALC situation in the region is untenable and remains a priority for all leaders in our communities who are making a concerted effort to introduce new initiatives and improvements.

As highlighted previously, emergency room issues, housing needs, and aging at home programs are all integrally linked to the ALC challenge. Our climate, geography, demographics and cultural diversity add to the challenge.

The complex nature of the problem is obvious - there is no single solution. Approaches need to be varied by individual communities to effectively address the situation and reverse the trend over time.

As outlined in the NE LHIN ***ALC Action Plan, December 2007***, a range of strategies and approaches have been identified to address the ALC challenge in the North East. The NE LHIN Action Plan addresses the ALC issue through six key strategies that focus on both resource / capacity issues and improvements in processes of care delivery.

Resource/Capacity Strategies:

The following strategies relate to the continuum of services required to provide an optimum range of services and supports for patients to allow for the appropriate care being delivered in the appropriate setting.

1. Improved health programs for seniors at home.
2. Prevention of senior hospital admissions in hospital emergency departments.
3. Accelerated senior discharge after completion of hospital acute episode.
4. Optimal configuration of community-based residential options and appropriate programs within those settings.

Provincial Alternate Level of Care Definition
(*Adopted July 2009*)

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health, or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at the time by the physician or her/his delegate.

The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Improvements in Processes of Care Delivery:

5. Improved hospital performance related to seniors.
6. Improved health system performance and integrated care pathways.

These streams all have short-, medium-, and long-term components and projects that are geared towards reducing current ALC pressures and occupancy (i.e. direct impact) and stemming the flow into hospitals (i.e. diversion and prevention).

Expected Outcomes:

In keeping with the identified strategies outlined above, the NE LHIN and our health care and community partners have implemented a range of initiatives to address the ALC challenge over the past two years. This is considered to be a sound start and the NE LHIN recognizes that there is still a long way to go before a resolution is reached. Our priorities for the coming years will continue to reflect a balanced mix of initiatives.

The North East LHIN will work closely with all partners to implement community-specific programs that provide viable alternatives to institutional care, such as:

- Available Aging at Home and Urgent Priorities funding targeting the ALC challenge
- Working collaboratively with municipalities and other stakeholders to increase the supply of affordable senior supportive housing / assisted living resources
- Improving pre-admission screening, discharge planning, service coordination, and system-wide case management
- Standardizing ALC monitoring mechanisms to assess progress.

DIABETES CARE

Diabetes is a chronic and ongoing disease that occurs when the body cannot produce sufficient insulin, resulting in a high level of sugar in the blood. When diabetes is not managed, it can lead to other illnesses. Combined with high blood pressure, high cholesterol, and smoking, uncontrolled diabetes can cause heart attacks, stroke, amputations, blindness, kidney failure, and even death.

In Ontario each year 23,000 people will discover they have diabetes. Approximately 165,000 people visit emergency departments annually in Ontario due to diabetes. Alarmingly, the number of people in the province with diabetes has increased 69% over the last 10 years. Approximately 10% of the North East LHIN's population has diabetes, in comparison to 8.8% for the province as a whole. Aboriginal populations are known to have significantly higher rates of diabetes.

Prevalence of Diabetes	
Planning Area	**% of Total Population**
Algoma	8.0%
Cochrane	10.0%
James and Hudson Bay Coasts	23.4%
Manitoulin-Sudbury	9.1%
Nipissing	9.1%
Parry Sound	7.6%
Timiskaming	9.1%
NE LHIN	9.6%
Ontario	8.8%*

ICES, Diabetes in Ontario – NELHIN, Trends in Diabetes Prevalence, Incidence and Mortality / 2004-05.
** MOHLTC & Ministry of Health Promotion. Backgrounder: Diabetes Strategy. July 22, 2008. Retrieved June 25th, 2009 from: http://www.health.gov.on.ca/en/news/release/2008/jul/diabetes_strategy_bg_final_20080722.pdf*

The impact of diabetes is dramatic but it can be controlled. Many of the 900,000 Ontarians who have diabetes suffer with preventable complications. The combination of healthy diet, exercise, and appropriate medications can control complications associated with diabetes. Common laboratory tests and simple procedures can be used to monitor the health of those with diabetes. These tests include measuring cholesterol levels, blood sugar, blood pressure monitoring, and retinol eye examinations.

Expected Outcomes:

- The Ontario Diabetes Strategy will help prevent, manage and treat diabetes by providing better access to information, education and best practice care
- Ontario's eHealth Strategy 2009–2012 has identified diabetes management as one of its clinical priorities. Four solutions will be developed:
    - The Baseline Diabetes Dataset Initiative will identify Ontarians with diabetes and match them to appropriate care
    - A Diabetes Registry will electronically monitor adherence to best practices and whether patients receive appropriate interventions
    - Electronic Medical Record system compatibility with the Diabetes Registry will enable physicians to exchange data
    - Lab test results will be linked to the Diabetes Registry as a resource for treatment
- Funding to improve access to insulin pumps and supplies
- Expansion of chronic kidney disease services including greater access to dialysis services
- Implementation of a strategy to expand access to bariatric surgery to address obesity
- Increased access to team-based care closer to home to address service gaps
- Educational campaigns to prevent diabetes by raising awareness of diabetes risk factors in high risk populations such as the Aboriginal / First Nations / Métis communities. Agreement with these communities to participate in the Diabetes Strategy will be an important first step.
- Investment in the necessary information technology infrastructure to support the Diabetes Strategy.

Methods of addressing other chronic diseases will happen as a result of successes gained in the area of diabetes.

EMERGENCY DEPARTMENT WAIT TIMES

In October 2007, the Ministry of Health and Long-Term Care announced that the Ontario Wait Times Strategy to improve access and reduce wait times for clinical services was being expanded to include emergency department (ED) wait times. Over 60% of unscheduled visits to emergency departments in the NE LHIN are for less urgent or non-urgent care needs. The table below provides details for our hospitals by planning area.

North East Ontario Unscheduled Emergency Department Visits 2008/2009			
Planning Area	**Total Visits**	**Total Non-Urgent and Less Urgent Visits**	
		Number	% Visits
Algoma	104,605	56,096	53.6%
Cochrane	93,210	66,782	71.6%
James & Hudson Bay Coasts	NA	NA	NA
Manitoulin-Sudbury	101,868	46,818	46.0%
Nipissing	68,824	42,063	61.1%
Parry Sound	22,097	15,015	68.0%
Timiskaming	43,936	34,651	78.9%
TOTAL	**442,294**	**269,162**	**60.9%**

Source: Ambulatory Care Main Table, intelliHEALTH, extracted August 26, 2009.

** Canadian Emergency Department Triage and Acuity Scale (CTAS): A method of categorizing the severity of illness for emergency department patients in Canadian hospitals. CTAS scores 4 and 5 are less urgent and non-urgent visits respectively.*

The use of EDs for non-urgent and less urgent needs reflects the scarcity of primary care options (particularly after hours) in many communities across the North East.

Reducing ED wait times and improving access to alternate levels of care will result in better patient care and increased patient satisfaction, while helping to improve:

- The ability of EDs to quickly treat patients needing urgent care
- The wait time between being designated ALC to discharge from acute care
- Access to community services so patients can remain at home and/or be discharged directly home.

Expected Outcomes:

- Develop: e-referral and resource matching to expedite patient referrals out of acute care and divert ED visits a wait time information system to provide detailed information about waits for post-acute care and an ED reporting system to capture information on hospital ED length of stay to facilitate performance management
- Ensure appropriate utilization of hospital beds and resources
- Improve capacity management including surgical flow
- Ensure that community services are available to enable patients, wherever possible, to avoid visiting the ED
- Expand community-based projects to manage selected chronic diseases
- Support comprehensive performance improvement training with respect to ED patient flow
- Increase case management and system navigation
- Support the North East LHIN's Emergency Department Network (that will address, among other things, a coordinated coverage plan for all 25 EDs in the North East)
- Improve triage and admission processes
- Implement strategies to reduce ALC pressures.

FRENCH LANGUAGE HEALTH SERVICES – AN INTEGRATED APPROACH

Effective engagement with Francophone stakeholders is a high priority of the NE LHIN. Recent consultations for the purpose of validating the priorities in this IHSP indicated that an integrated approach to addressing challenges for French Language Health Services (FLHS) is required, specifically integration of FLHS within each priority and the inclusion of an integrated approach within the mission and vision of the NE LHIN.

The NE LHIN is awaiting provincial direction on the development of the local French Language Health Services Entity. In the interim, the NE LHIN, with the help of FLHS providers, has identified the following three main objectives to guide French language planning activities:

- Continuous improvement in the quality, accessibility and integration of FLHS
- Community empowerment and continued community engagement in order to impact the overall health system and improve health status
- Accountability of health service providers to their community.

A major achievement for the NE LHIN with respect to FLHS includes an accountability reporting tool that was part of recent service accountability agreements.

This reporting tool is to be implemented by hospital and community service providers to

determine how equitable they are at providing access to health services in French for Francophone clients.

Expected Outcomes:

- Build on the success of the work of the Réseaux de services de santé en français and the report *Préparez le terrain*, 2007
- Support the implementation and work of the Interim French Language Service Planning Entity to establish a clear vision for French language services
- Move forward with the implementation of the French Language Health Services policy to guide the North East LHIN in identifying and responding to the needs of Francophones
- Continue engagement with FLHS providers and Francophone communities
- Monitor progress with regards to access to services in French for Francophone clients.

HEALTH HUMAN RESOURCES

Ontario's vision for health care embraces a goal that there will be the right number and mix of health care professionals, when and where they are needed.

Health human resources (HHR) and timely access to the necessary health professionals in the North East is perhaps the challenge most frequently identified challenge by all individuals working in health care. Throughout the IHSP engagement activities, this challenge remained the number one topic of discussion.

When compared to Ontario and the rest of Canada, the North East region has significant shortages in a number of health human resources areas including: physician specialists, physiotherapists, and occupational therapists. However, there are instances where the number of professionals in the North East compares favourably to Ontario and Canada on a per capita basis; nonetheless there is a significant mal-distribution in the region with many communities experiencing ongoing shortages. Chronic vacancies which already exist are made worse by both the aging of the health service workforce and general population as a whole. This leads to an increasing demand for services.

Each of the IHSP priorities has a human resources dimension. The challenges facing our health care system and the providers within it are well documented. The NE LHIN will work with the province, local health service providers, communities and individuals to determine innovative ways to attract additional professionals to the region and retain them.

The North East Health Human Resources Steering Committee was established in early 2009. The Committee provides system-wide leadership in the development of the North East Ontario Health Human Resources Plan which gives consideration to local, cultural and language-related HHR issues.

A comprehensive range of HHR planning and coordination activities is required to support the delivery of health services within the North East LHIN, including:

- An inventory of HHR in the North East
- A list of current vacancies with recent historical experience
- Projections of future HHR needs
- Strategies for recruiting and retaining needed HHR.

The following structures have been established to support the Committee's workplan over the next 18 to 24 months:

- Personal Support Occupations Task Force
    - working Conditions / Workforce Retention Working Group
    - workforce Education and Training Working Group
- HHR Inventory / Forecasting Sub-Committee
- HHR Issues Identification Sub-Committee.

Expected Outcomes:

- Develop a series of strategies which are founded on collaboration / integration opportunities to mitigate the HHR challenges
- Develop and implement recommendations for a structure that will facilitate action on the necessary strategies
- Active participation of the French language and the Aboriginal / First Nations / Métis health services communities to determine the best strategies to mitigate the unique HHR challenges within these populations
- Establish partnerships with post-secondary institutions to position them to meet HHR needs
- Define and implement the functional requirements of a real-time North East Ontario Human Resource Information System.

OPTIMIZE SURGICAL SERVICES

Provincially, the Ontario government has been implementing a plan to increase access and reduce wait times for five major surgical services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as certain diagnostic exams.

Aligned with the provincial focus and as a result of discussions with key stakeholders from across North East Ontario, the NE LHIN undertook a review of surgical services currently being delivered in hospitals throughout the region to ensure that access and quality of care are maintained in the future.

The mandate of the project was to review the surgical volumes, diagnostics and resource requirements to meet North East Ontario's surgical needs. A Surgical Optimization Project Steering Committee was put in place to look at the patterns of use of surgical services within the region and identify surgical specialities needing further review and discussion with stakeholders.

These specialities were led by task forces in the following areas:

- Gynaecology
- Orthopaedic Surgery
- Thoracic Surgery
- Urgent and emergent access to surgical specialty services
- Urology
- Vascular Surgery.

Expected Outcomes:

The first phase of the Surgical Optimization project is now complete and the Steering Committee is moving forward with a three-year action plan to carry out the 33 recommendations stemming from the *Surgical Optimization Study Report*, May 22, 2009 (www.nelhin.on.ca). The following provides an overview of the categories of recommendations that are to be addressed for the next three years:

Year 1

- Thoracic surgical oncology – meeting Cancer Care Ontario (CCO) standards
- Orthopedic – addressing wait time targets and repatriation issues
- Call schedules – identification of coordinating mechanisms
- Itinerant surgeons – setting parameters for the use of itinerant surgeons
- Funding allocation – monitoring provision of surgical services by NE LHIN hospitals
- Health Based Allocation Model (HBAM) – ensure the needs of the North East are taken into account
- Payment rates – access to appropriate specialist locum funding rates
- Neurology – access to neurosurgical services
- Trauma – access to trauma care
- Inpatient surgical beds – access to appropriate number of beds at Hôpital régional de Sudbury Regional Hospital

Year 2

- HHR – inventory of surgical resources and development of a surgical health human resource plan
- Vascular surgery – plan to consolidate services.
- Call schedules – implementation of a call schedule for district and regional surgical services to address gaps and wait times
- Gynecology – development of protocols between gynaecologists and urologists for specific procedures

Year 3

- HHR – roll-out of surgical human resource plan to address access to general surgeons across North East
- Impact analysis – analysis of hospitals' ability to support their designated surgical role
- Itinerant surgeons – implementation of the parameters across the hospitals in the North East
- Integrated care pathways – development of standard integrated pathways for common surgical procedures.

SECTION 7: RATIONALE FOR THE STRATEGIC DIRECTIONS

As outlined in the diagram below, the selection of the strategic priorities for the next three years has come as a result of a wide range of inter-related activities from consultation, to information analysis, to an assessment of the provincial context and environment.

In order to establish and subsequently confirm the IHSP for 2010-2013, the priorities and strategic directions were based on consideration of feedback received from:

- Six local community engagement sessions attended by over 100 participants held in Hearst, New Liskeard, Sault Ste. Marie, Little Current, Sturgeon Falls and Sundridge
- Seventeen meetings with established community and NE LHIN planning tables, networks and committees
- Sixty-seven participants at a Francophone forum
- Approximately 140 responses to an online survey
- Approximately 200 participants at a governance / stakeholder forum
- Sixty participants at two Aboriginal / First Nations / Métis dialogues.

The priorities reflect a mix of issues that will be addressed by the NE LHIN due to:

- The challenges some of these priorities are having on the system (i.e. ALC, emergency department utilization, diabetes care)
- The fact that the North East will face significant demographic changes (i.e. Aging at Home, health human resources)
- The representation of clear and known opportunities to improve services (i.e. addiction and mental health, surgical programming)
- The challenges and needs of our culturally diverse populations to access health services (i.e. Francophone and Aboriginal / First Nations / Métis).

As noted previously, the interdependence between the priorities and many of the strategies means that success in one area will have a positive impact on other priorities - this is the cornerstone of *integrated* health service planning.

SECTION 8: HOW SUCCESS WILL BE DEMONST RATED AND MEASURED

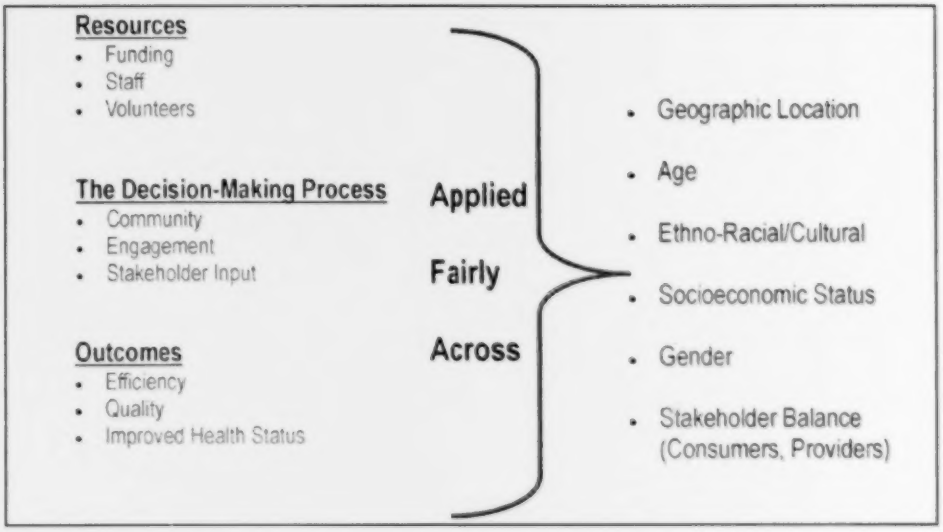
Equity and accessibility refers to the fair, just and optimal distribution of resources and services. Ensuring that the right type and number of services are available across the North East is both critical and challenging in achieving our vision of *health and wellness for all*.

The Local Health Integration Act states that "*the people of Ontario and their government believe that the health system should be guided by a commitment to equity and respect for diversity in communities.*" To enhance equity, the health system's policies and practices must be changed and our decision-making processes must be more inclusive. The Act recognizes "*the need for communities, health service providers, Local Health Integration Networks, and the government to work together to reduce duplication and better coordinate health service delivery to make it easier for people to access health care. The government envisions an integrated health system that delivers the health services that people need, now and in the future.*"

Clients must be able to find their way through the health system easily and quickly as their needs for services change. Service integration and partnerships, together with improved electronic health record technology, will support high quality health services where patients do not have to repeat health history or tests for each service provider.

In an effort to make programs and services more equitable, the NE LHIN has attempted to assess gaps and measure improvements in equity across the region. The following diagram has been used as a tool to evaluate the fair distribution of limited resources throughout the North East. The considerations include: resources, the decision-making process, and outcomes. The distribution of these resources is matched to categories such as: age, gender, geographic location, socioeconomic status, ethno-racial/cultural, and consumer–provider perspectives.

North East LHIN Equity and Access Framework



As part of this pursuit of equity, the NE LHIN has developed decision-making criteria to serve as a guide in evaluating proposals for new programs and initiatives, changes to existing programs, and integration proposals.

North East LHIN Decision-Making Criteria

Criteria	Measures
Strategic and Ethical Fit	• Aligned with the NE LHIN's mission, vision, values and IHSP. • Public interest.
Access	• Meet residents' access needs. • Coordinate response to patient needs by a variety of related services.
Efficiency and Sustainability	• Minimize overhead, administrative, and indirect expenses. • Minimize duplication. • Minimize capital costs. • Reduce intensive resource utilization. • Achieve performance targets where they have been identified. • Promote innovation.
Quality	• Consistency with patient/client-centered health care. • Critical mass for program competence and sustainability. • Patient/client and workforce safety. • Evidence of best practice.

Criteria	Measures
Coordination of Care	▪ Improved coordination and collaboration of services for patients/clients across the continuum. ▪ Positive impact on the local health system. ▪ Alignment with provider role.
Community Engagement	▪ Demonstrated engagement of health service and community partners. ▪ Sensitivity to the needs of the Francophone and Aboriginal / First Nations / Métis populations.
Local Considerations	▪ To be determined on a case-by-case basis.

Measuring our Success

The Ministry-LHIN Accountability Agreement (MLAA) clearly defines the relationship between the MOHLTC and the LHIN in the delivery of local health care programs and services. A shared understanding is created between the Ministry and the LHIN that outlines deliverables and time frames.

The NE LHIN MLAA performance indicators will be measured against provincial expectations and targets for various surgeries, diagnostic procedures, re-admission rates, emergency department visits that could be managed elsewhere, and hospitalization rates for ambulatory care sensitive conditions. In addition and in support of the development of integrated French language services, the NE LHIN has also included FLHS as a specific performance indicator.

The North East LHIN will participate fully in the various reporting mechanisms (that are in place or planned) to the MOHLTC and community on items such as financial performance, ALC and wait times.

The following diagram depicts the accountability framework that the NE LHIN will follow. The framework is evidence of the planning, ongoing operations and reporting to the Ministry and the broader public.

As of December 2009, the NE LHIN will report to the public through a balanced scorecard posted to its website. The NE LHIN scorecard reports performance across four domains that are the centre of the LHIN's vision – *"Health & Wellness for All …through an innovative, sustainable and accountable system."* These domains are: 1) client access and outcomes; 2) system integration; 3) financial health and system sustainability; and 4) organizational health.

The NE LHIN looks forward to additional ways of reporting to the public on successes resulting from partnerships and innovations in the way we plan for and achieve improvements to our health care system throughout the North East.